



PA13-2004: LONG ACTING NARCOTICS REQUEST

RI MEDICAL ASSISTANCE PROGRAM PRIOR AUTHORIZATION REQUEST FORM

NOT REQUIRED FOR RECIPIENTS UNDER 21 YEARS OF AGE.

CLIENT NAME: _____ DOB: _____ MEDICAID ID NUMBER: _____
PRESCRIBER NAME: _____ PRESCRIBER DEA #: _____
PRESCRIBER OFFICE ADDRESS: _____
OFFICE PHONE NUMBER () _____
REQUESTER NAME: _____ RN /MD /R.Ph / _____
PHONE NUMBER: () _____ FAX NUMBER: () _____
DRUG REQUESTED: _____ STRENGTH: _____ QTY / FILL: _____
START DATE: _____ DOSING FREQUENCY: _____

CRITERIA SPECIFICATIONS ARE AVAILABLE BY CALLING **(401) 784-8100** OR AT WEB ADDRESS
www.dhs.ri.gov/dhs/heacre/provsvcs/mpharpa.htm

HAS THE PATIENT BEEN DIAGNOSED WITH CANCER IN THE PAST 2 YEARS? Yes / No

IF YES, PLEASE LIST THE APPROPRIATE ICD-9 CODE ICD9 CODE _____

HAS THE PATIENT BEEN DIAGNOSED WITH NEUROPATHY IN THE PAST 2 YEARS
OR CHRONIC NON-MALIGNANT PAIN WITHIN THE PAST YEAR? Yes / No

IF YES, PLEASE LIST THE APPROPRIATE ICD-9 CODE ICD9 CODE _____

IN THE PAST 30 DAYS, HAS THE PATIENT EXCEEDED THE AVERAGE DAILY CEILING DOSES
OF OPIATE PRODUCTS CONTAINING ACETAMINOPHEN (GREATER THAN 4000MG/DAY) OR
IBUPROFEN (GREATER THAN 3200MG/DAY)? Yes / No

HAS THE PATIENT BEEN RECEIVING PRESCRIPTION QUANTITIES OF C-II
AND/OR C-III OPIATE COMBINATION PRODUCTS FOR MORE THAN 30 DAYS? Yes / No

COMMENTS:

PREScriBER SIGNATURE _____ **DATE** _____

By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.

FAX OR MAIL TO: **FAX NUMBER 1-800-390-0109**
HERITAGE INFORMATION SYSTEMS
ATTN: RI PRIOR AUTHORIZATION UNIT
PO Box 25719
RICHMOND, VA 23286-8212
TELEPHONE NUMBER 1-866-420-3874

CALL CENTER HOURS
MONDAY – FRIDAY 9:00 AM – 6:00 PM (EST)
FAX NUMBER 1-800-390-0109 (AVAILABLE 24 HOURS)